DWS-HCD 871
Rev 08/2014

Department of Workforce Services

H.E.A.T. PROGRAM/HELP/EAF APPLICATION (Home Energy Assistance Target)

One Person Household — H.E.A.T. Application

1. Applicant information:

Name: _____ Date: _____
First Middle Last

Social Security #: _____ Gender: ☐ Male ☐ Female Birth Date: _____
Month Day Year

Address: _____ City/State:_____ Zip: _____

Phone number: _____ Email: _____

2. Have you applied for HEAT assistance before? ☐ Yes ☐ No If yes, Date: _____ Office: _____

3. Ethnic background: ☐ American Indian ☐ White ☐ Hispanic ☐ Black ☐ Asian
☐ Pacific Islander ☐ Other: _____

4. Are you: U.S. Citizen: ☐ Yes ☐ No Age 60 or older: ☐ Yes ☐ No
Handicapped/Disabled: ☐ Yes ☐ No SNAP Recipient (Food Stamps): ☐ Yes ☐ No

5. Your dwelling is a: (check one): ☐ House ☐ Apartment (3 or more units) ☐ Duplex ☐ Basement apartment
☐ Mobile home ☐ Condo ☐ Townhouse ☐ Boarding room ☐ Small trailer

6. Do you rent or own your home? ☐ Rent ☐ Own What is your primary heating source? _____

What is your secondary heating source? _____ What is your primary cooling source? _____

7. Is your rent subsidized? ☐ Yes ☐ No How much is your monthly rent/mortgage payment? $ _____

8. Does your rent include utilities? ☐ Yes ☐ No
(If so, please include a copy of the lease or a signed Landlord Statement form must be included with application)

Which utilities? _____

9. Does anyone else live with you now? ☐ Yes ☐ No If yes, make an appointment with your local HEAT office (dial 2-1-1). This application is for one-person households only.

10. Please enclose copies of your most recent utility bills. HEAT payment is to be issued to the following utility vendor(s) in the percentages listed below (100%,50/50%, or 25/75%). Payment cannot be changed once application is submitted: Be sure to circle the account status for each utility. If you circle 48 hr. you must include a copy of the 48 hour shut-off notice. For propane, circle **on** if you have fuel, **off** if you are out of fuel, and 48 hr. if you will run out of fuel within 48 hours.

%	Name of Utility Vendor(s)	Account Status (circle one)	Utility Account Number(s)	Name on account (provide explanation if not applicant)
		on / off / 48 hr		
		on / off / 48 hr		

Name of electricity vendor and account number if not included above:_____

Equal Opportunity Employer Program
Auxiliary aids and services are available upon request to individuals with disabilities by calling (801) 526-9240. Individuals with speech and/or hearing impairments may call Relay Utah by dialing 711. Spanish Relay Utah: 1-888-346-3162.

11. Income (please enclose documentation of income): Enter the gross amount of income you received **last month** from each source.

Income documented is for the month of: _____.

Wages (Part-time/Full-time/Self-emp.)	$_____	Unemployment	$_____
Railroad Retirement	$_____	Supplemental Security Income (SSI) ...	$_____
Veterans Benefits	$_____	General Assistance	$_____
Social Security	$_____	Income from Rental Property	$_____
Pension/Annuity/Retirement	$_____	Other: _____	$_____

12. Deductions: Did you make any payments to doctors, hospitals, or medical/dental clinics, pay for any health, dental, or vision insurance premiums, or pay for prescription medicines, oxygen, glasses/contacts, or hearing aids **last month**?

☐ Yes ☐ No

If yes, please include copies of the receipts with this application. All receipts must be paid in the same month as the month of income listed above.

Total Income: $ _____ Total Deductions: $_____ Net Income: $ _____

DECLARATION: I understand that neither the vendor nor the percentage of my H.E.A.T. payment may be changed. By signing this application, I certify under penalty of perjury that the information I provided on this application is true, and that giving false information may require repayment of any funds received. I agree to cooperate with state and federal officials in any review of my application and to provide information necessary to verify any statement herein. I give permission for my utility companies to provide my billing and usage information to the state of Utah. I hereby authorize H.E.A.T. program officials to make inquiry of persons, companies, financial institutions, and other state and federal agencies to assist in the processing of my application. I understand that if I do not provide the necessary information to establish my eligibility within 10 days from this date that my application may be denied. I understand that I have the right to a Fair Hearing if my application is denied. I further understand that if Federal H.E.A.T. funds are exhausted prior to processing this application, the State of Utah is under no obligation to make payment. I understand that if my application is denied or if the local office has failed to act upon my application within 45 days, I have the right to request a Fair Hearing. I verify that, if eligible, I would like to receive the Rocky Mountain Power (RMP) HELP discount program and Questar Gas Energy Assistance Fund (EAF) credit.

_____ _____

Signature Date

OFFICE USE: Office Code: _____ Worker: _____ Editor: _____ Fuel Type: _____

☐ House Standard ☐ Apartment Standard ☐Room/board ☐Actual amount $_____